HENRY-MARTINSVILLE HEALTH DEPARTMENT
PO BOX 1032
MARTINSVILLE, VA. 24114

School Consent for Hepatitis B Vaccine

Name: _____
Date of Birth: _____
Race: _____
Address: _____
Phone #: _____
SS#: _____
Circle: Male or Female
Does your child have Health Insurance? Circle: Yes or No
If your child is on Medicaid please list the Medicaid number below.
_____

Immunization Encounter Form
Informed Consent For Immunization

I hereby authorize the doctors, nurses or nurse practitioners of the Virginia Department of Health to immunize my child named above. I understand the risks and benefits of the immunizations checked below and have had the opportunity to ask questions. I have received VACCINE INFORMATION STATEMENTS or information sheets about the immunizations. I agree that my child's immunization record, date of birth, and address may be shared with other health care providers. I understand that this information will be used by health care providers for the care of my child and for statistical purposes only. I understand that this information will be kept confidential. The Deemed Consent for blood borne diseases has been explained to me and I understand it. I understand that medical records must be kept for 5 years after death, 10 years after my last visit, or 5 years after age 18 for my minor child.

_*Diphtheria, tetanus, pertussis, haemophilus influenza B*
_*Oral polio vaccine*
_*Hepatitis B*
_*Measles, mumps, rubella*
_*Diphtheria, tetanus, acellular pertussis*
_*Haemophiilus influenza type B*
_*Diphtheria, tetanus*
_*Tetanus, diphtheria*
_*Enhanced inactivated polio vaccine*
Other: _____
Other: _____
Other: _____

_____Date
_____
Patient, Parent/Legal Guardian, Person Acting in Loco Parentis

_____
Signature of Provider
***Form should be retained as an informed consent**